

## Public Report

**Report Issue Date:** August 18, 2025

**Inspection Number:** 2025-1100-0003

**Inspection Type:**

Complaint

Critical Incident

**Licensee:** Kindera Living Care Centres LP by its general partners, Kindera Living Care Centres GP Inc. and Kindera Living Management Inc.

**Long Term Care Home and City:** Hawthorne Place Care Centre, North York

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 5-8, 11-13, 15 and 18, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00149560 - was related to the alleged abuse from resident to resident
- Intake: #00153463 - was related to a fall of a resident resulting in injury

The following intake was inspected in this complaint inspection:

- Intake: #00152981 - was related to resident care and services.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services  
Prevention of Abuse and Neglect  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Toronto District  
5700 Yonge Street, 5th Floor  
Toronto, ON, M2M 4K5  
Telephone: (866) 311-8002

**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in a resident were monitored in accordance with any standard or protocol issued by the Director.

A resident presented with a sign of infection and a diagnostic test was ordered. The resident was discharged from the home and subsequently was diagnosed with an infection. The resident was not assessed and monitored for the infection before they were discharged.

**Sources:** Resident's clinical records, interviews with home's staff and Infection Prevention and Control (IPAC) leads.